| STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION | (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: | (X2) MULTIPLE CONSTRUCTION | (X3) DATE SURVEY COMPLETED |
| --- | --- | --- | --- |
| | 555567 | A. Building<br>B. Wing | 04/25/2024 |

| NAME OF PROVIDER OR SUPPLIER | STREET ADDRESS, CITY, STATE, ZIP CODE |
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| South Coast Global Medical Center D/P Snf | 2701 South Bristol Street<br>Santa Ana, CA 92704 |

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| F 0557<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Honor the resident's right to be treated with respect and dignity and to retain and use personal possessions.<br><br>48853<br><br>Based on interview, medical record and the facility P&P review, the facility failed to ensure the resident's personal belongings were properly recorded for one of the two sampled residents (Resident 1). This failure had the potential for residents personal belongings being lost.<br><br>Findings:<br><br>Review of facility's P&P titled Handling of Personal Effects revised on July 2006, showed all residents will have the right to retain and use personal possessions unless to do so would infringe upon the rights and health or health and safety of other residents. All steps will be taken to protect the personal effects of all residents. On admission, have resident or responsible party sign the form after completion of the inventory. For new items brought to hospital after admission: record, date and sign the back of the Resident's Inventory form when new items are brought to hospital by family members.<br><br>Review of Resident 1's Resident Inventory of Personal Effects showed:<br><br>- 3/15/22 failed to show staff signature and responsible party signature<br><br>- 5/1/22 failed to show responsible party signature<br><br>- 10/30/22 failed to show responsible party signature<br><br>- 1/31/23 failed to show responsible party signature<br><br>- 4/18/23 failed to show responsible party signature<br><br>- 6/24/23 failed to show staff and responsible party signature<br><br>On 4/23/24 at 0935 hours, a concurrent interview and medical record review were conducted with the DSD. The DSD stated personal belongings inventory were supposedly updated each time a resident representative brings in or removes belongings from the facility. DSD verified Resident 1's Resident Inventory of Personal Effects Forms were incompletely filled out for accountability as above.<br><br>(continued on next page) |

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

| LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE |
| --- | --- | --- |

Printed: 08/01/2024
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No. 0938-0391

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| F 0557<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/24/24 at 1108 hours, a phone interview with Family Member 1 was conducted. Family member 1 stated Resident 1 had lost a lot of blankets and clothes since Resident 1 was admitted to the facility. Family Member 1 stated she is aware of the procedure to inform the facility of the items brought into or removed from the hospital, however, the inventory of personal effects was not being consistently done by the staff which made it difficult to track the missing items.<br><br>On 4/24/24 at 1409 hours, an interview with the DON was conducted. The DON stated two of the blankets Resident 1 was missing was replaced. The DON was made aware of the findings and acknowledged the above findings. |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Provide care and assistance to perform activities of daily living for any resident who is unable.<br><br>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** 48853<br><br>Based on observation, interview and medical record review, the facility failed to provide the necessary care and services to ensure four of four sampled residents (Residents 1, 2, 3, and 5) maintained good grooming, personal hygiene, and transfers for dependent residents. These failures had the potential for the residents to experience physical discomfort, emotional distress, health complications, and a decreased quality of life.<br><br>* Resident 1 did not received shower as scheduled and was not transferred out of bed as scheduled.<br><br>* Resident 2 did not received shower as scheduled and has long fingernails.<br><br>* Resident 3 did not received shower as scheduled and was not transferred out of bed as scheduled.<br><br>* Resident 4 had long fingernails.<br><br>Findings:<br><br>Review of facility's P&P titled Activities of Daily Living (ADL) reviewed on August 2023, showed personal hygiene includes bathing (bed), showering (via gurney), oral care, hair and nail care, skin care and bed mobility and repositioning and pressure reducing devices used. Bed bath will be given daily except on the days resident receives a shower. Showering will be at least twice per week. Nail care includes daily cleaning and regular trimming.<br><br>Review of facility's P&P titled Care of Nails revised om November 2010 showed fingernails can be partially cleaned during handwashing and bath care. Nail care includes daily cleaning and regular trimming. Proper nail care can aid in the prevention of skin problems around the nail bed. Trimmed and smooth nails prevent the resident from accidentally scratching and injuring his or her skin.<br><br>1. Review of Resident 1's medical record was initiated on 4/22/24. Resident 1's medical record showed, Resident 1 was admitted on [DATE]. The H&P dated 9/20/23 showed resident had major stroke, remains nonverbal, responds to questions or requests by nodding and paralyzed on the right side, resident has purposeful movement on left upper extremity and at times has repetitive left lower extremity flexor movement at the hip site.<br><br>Review of Resident 1's MDS Quarterly assessment dated [DATE], showed Resident 1 was rarely or never able to express ideas and wants and sometimes able to understand other. Resident 1 is dependent with oral hygiene, toileting, showers, upper and lower body dressing, putting on or taking off footwear, personal hygiene, and chair to bed or bed to chair transfers.<br><br>Resident 1's plan of care showed a care plan problem dated 3/19/24, addressing actual self-care deficit at risk for further decline in ADL's. The approach plan includes give shower two times weekly and bed bath daily, transfer out of bed using Hoyer lift (Hoyer Lifts allow a person to be lifted and transferred with a minimum of physical effort) with 2 persons assist.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of facility's Sub-Acute Activity Schedule not dated, showed Resident 1 was scheduled to be up in a wheelchair on Sundays 0900-1100 hours and on Tuesdays and Thursdays 1300 -1500 hours.<br><br>Review of Resident 1's CNA flowsheet, activity, and nurses progress notes for the month of April 2024 failed to show resident received a shower on 4/9/24, and 4/19/24. Additionally, the CNA flowsheet, activity, and nurses progress notes for the month of April 2024 failed to show Resident 1 was transferred in wheelchair on 4/2/24, 4/6/24, 4/13/24, and 4/20/24.<br><br>On 4/22/24 at 1200 hours, a phone interview with Family Member 1 was conducted. Family Member 1 expressed dissatisfaction with the staffing, stated the facility is always short of staff most of the time and was not able to give showers and get Resident 1 up in wheelchair as scheduled. Family Member 1 stated Resident 1 was supposed to received shower twice a week and should be transferred to the wheelchair at least three times a week. Additionally, Family Member 1 stated Resident 1 sometimes has foul smelling body odor, oily skin, and hair.<br><br>On 4/22/24 at 1455 hours, an interview with LVN 1 was conducted . LVN 1 stated there were inevitable instances wherein resident do not receive shower and transferred to wheelchair because of shortage of staffing.<br><br>On 4/24/24 at 1121 hours, an interview with CNA 2 was conducted . CNA 2 expressed taking care of nine to ten totally dependent residents were very hard. The shortage of staff happens any day of the week during the weekdays and more so on the weekends. CNA 2 further stated at times the staffing is short he was not able to give the assigned shower to the residents and unable to get the resident up in wheelchair as scheduled.<br><br>On 4/24/24 at 1135 hours, an interview with LVN 3 was conducted. LVN 3 stated shortage of staffing happens at least two to three times in a week. LVN 3 admits he had to personally help the resident to clean and change soiled clothing of the residents.<br><br>On 4/24/24 at 1400 hours, LVN 4 stated the RNA was pulled from doing RNA duties at 1000 hours today to work as a CNA.<br><br>On 4/24/24 at 1409 hours, an interview was conducted with the DON, the DON verified Resident 1's scheduled shower days are on Mondays and Fridays. The DON confirmed staffing challenges with the CNAs and RNAs at the facility. The DON cited several CNAs quitting and calls in sick at times. The DON stated they are working hard to get enough CNAs and RNAs in the facility for the residents to receive the necessary care. Additionally, DON stated most CNAs turned down the facility's offer for employment and the CNA or RNA registry would not like to work in the sub-acute unit.<br><br>On 4/24/24 at 1536 hours, an interview with RNA 1 was conducted. RNA 1 confirmed he was being pulled out from RNA duty to care for residents as CNA today at 1000 hours. He was being pulled out least once or twice a week. RNA 1 stated whenever he was pulled out to take care of the residents as a CNA, he will not be able to provide the treatment such as range of motion exercises and put the required orthosis or splints to the residents as ordered by MD.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/25/24 at 1045 hours, a concurrent interview and medical record review with the DSD was conducted. The DSD verified Resident 1's CNA flowsheet, activity, and nurses progress notes for the month of April 2024 failed to show resident received a shower on 4/9/24, and 4/19/24. Additionally, the CNA flowsheet, activity, and nurses progress notes for the month of April 2024 failed to show Resident 1 was transferred in wheelchair on 4/2/24, 4/6/24, 4/13/24, and 4/20/24. The DSD confirmed the facility has challenges with CNA staffing.<br><br>2. Review of Resident 2's medical record was initiated on 4/22/24. Resident 2's medical record showed, Resident 2 was admitted on [DATE]. The H&P dated 7/27/23 showed resident had altered mental status and unable to provide history of illness.<br><br>Review of Resident 2's MDS Quarterly assessment dated [DATE], showed Resident 2 was in vegetative state and had no discernable consciousness. Resident 2 is dependent with oral hygiene, toileting, showers, upper and lower body dressing, putting on or taking off footwear, personal hygiene, and chair to bed or bed to chair transfers.<br><br>Resident 2' plan of care showed a care plan problem dated 6/24/24, addressing actual self-care deficit at risk for further decline in ADL's. The approach plan includes give shower two times weekly and bed bath daily.<br><br>Resident 2's CNA flowsheet and nurses progress notes for the month of April 2024 failed to show resident received a shower on Tuesdays on 4/2/24, 4/9/24, and 4/16/24.<br><br>On 4/23/24 at 1028 hours, Resident 2 was observed with long fingernails. Additionally, the right thumb fingernail had jagged edges with black colored matter under the fingernail.<br><br>On 4/23/24 at 1036 hours, an interview with LVN 2 was conducted. LVN 2 stated nurses usually cuts resident nails weekly and the activities helps with trimming the fingernails.<br><br>On 4/24/24 at 1402 hours, an interview with the activity assistant was conducted. Activity assistant stated she has not provided nail care for Resident 2.<br><br>On 4/24/24 at 1409 hours, an interview with the DON was conducted. The DON stated the nurses usually cut the residents fingernails and activities helps with the filing of the fingernails. The DON verified Resident 2's scheduled shower days are on Tuesdays and Fridays. The DON cited several CNAs quitting and calls in sick. The DON stated they are working hard to get enough CNAs and RNAs in the facility for the residents to receive the necessary care. Additionally, DON stated most CNAs turned down the facility's offer for employment and with the CNA or RNA registry would not work in the sub-acute unit.<br><br>On 4/25/24 at 1045 hours, a concurrent interview and medical record review with the DSD was conducted. The DSD verified Resident 2's CNA flowsheet and nurses progress notes for the month of April 2024 failed to show resident received a shower on Tuesdays on 4/2/24, 4/9/24, and 4/16/24. The DSD confirmed the facility has challenges with CNA staffing.<br><br>3. Review of Resident 3's medical record was initiated on 4/24/24. Resident 3's medical record showed, Resident 3 was admitted on [DATE].<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | Review of Resident 3's MDS Quarterly assessment dated [DATE], showed Resident 3 rarely or never able to express ideas, rarely or never understand s or understood. Resident 3 is dependent with oral hygiene, toileting, showers, upper and lower body dressing, putting on or taking off footwear, personal hygiene, and chair to bed or bed to chair transfers.<br><br>Resident 3's plan of care showed a care plan problem dated 2/5/24, addressing actual self-care deficit at risk for further decline in ADL's. The approach plan includes give shower two times weekly and bed bath daily, transfer out of bed using Hoyer lift (Hoyer Lifts allow a person to be lifted and transferred with a minimum of physical effort) with 2 persons assist.<br><br>Review of facility's Sub-Acute Activity Schedule not dated, showed Resident 3 was scheduled to be up in a wheelchair on Sundays, Tuesdays, and Thursdays at 1300 -1500 hours.<br><br>Review of Resident 3's CNA flowsheet and nurses progress notes for the month of April 2024 failed to show resident received a shower on Wednesday, 4/10/24, and Saturday, 4/13/24. Additionally, Resident 3's CNA flowsheet and nurses progress notes for the month of April 2024 failed to show resident was transferred to a wheelchair on 4/6/24, 4/9/24, 4/11/24, 4/13/24, 4/16/24, and 4/20/24.<br><br>On 4/24/24 at 1409 hours, an interview with the DON was conducted. The DON verified Resident 3's scheduled shower days are on Wednesdays and Saturdays. The DON cited several CNAs quitting and calls in sick. The DON stated they are working hard to get enough CNAs and RNAs in the facility for the residents to receive the necessary care. Additionally, DON stated most CNAs turned down the facility's offer for employment and the registry CNA or RNA would not work in the sub-acute unit.<br><br>On 4/24/24 at 1539 hours, a phone interview was conducted with Family Member 2. Family Member 2 stated the facility is usually short of CNA. Resident 3 do not receive shower as he is supposed to, and the staff do not get the resident up in the wheelchair as scheduled.<br><br>4. Review of Resident 5's medical record was initiated on 4/24/24. Resident 5's medical record showed, Resident 5 was admitted on [DATE]. The H&P dated 8/29/23 showed resident does not have the capacity to understand and make decisions.<br><br>Review of Resident 5's MDS Quarterly assessment dated [DATE], showed Resident was not able to express ideas. The resident rarely or never understands and make self-understood. Resident 5 is dependent with oral hygiene, toileting, showers, upper and lower body dressing, putting on or taking off footwear, personal hygiene, and chair to bed or bed to chair transfers.<br><br>Resident 5's plan of care showed a care plan problem dated 10/27/23, addressing actual self-care deficit at risk for further decline in ADL's. The approach plan includes nail care every bath, shower day and PRN.<br><br>On 4/24/24 at 1119 hours, Resident 5 was observed with long fingernails.<br><br>On 4/24/24 at 1121 hours, CNA 2 verified Resident 5's fingernails were long and not trimmed.<br><br>On 4/24/24 at 1135 hours, an interview was conducted with LVN 3 was conducted. LVN 3 stated sometimes nurses trim the residents nails however the activity usually trims the nails.<br><br>(continued on next page) |

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| F 0677<br><br>Level of Harm - Minimal harm or potential for actual harm<br><br>Residents Affected - Few | On 4/24/24 at 1402 hours, an interview with the activity assistant was conducted. Activity assistant stated she had not provided nail care for Resident 5.<br><br>On 4/24/24 at 1409 hours, an interview with the DON was conducted. The DON stated the nurses usually cut the resident's fingernails and activities helps with the filing of the fingernails. The DON was informed and acknowledge the findings as above. |